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AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

DATE AMENDED NOTICE SENT TO ALL PARTIES: Jan/22/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Functional capacity evaluation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the requested functional capacity evaluation is not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Multiple Clinical notes dated 05/16/14 through 12/17/14
Multiple therapy notes 07/25/14 through 11/13/14
MRI left knee 02/25/14 and 09/26/14
Operative notes 10/23/14 and 06/05/14
Adverse determinations 12/04/14 and 12/08/14

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male. The operative note dated 09/16/14 indicates the patient undergoing a left shoulder exam under anesthesia, arthroscopic debridement of the biceps tendon tear, and a repair of the torn glenoid labrum. The MRI of the left shoulder dated 08/05/14 revealed a partial subscapularis tendon tear with a medial biceps tendon subluxation. The therapy note dated 11/13/14 indicates the patient having undergone 24 physical therapy sessions to date. The clinical note dated 08/15/14 indicates the patient complaining of left shoulder pain. The patient stated the initial injury occurred when he was trying to move an end bell on a motor when it suddenly slipped off throwing his arm and subsequently injuring the shoulder. The note indicates the patient having initially maintained good range of motion. The clinical note dated 09/29/14 indicates the patient presenting for a follow up regarding the left shoulder surgery. The patient was able to demonstrate 140 degrees of flexion and 130 degrees of abduction at that time. No infection was identified at the surgical wounds. The clinical note dated 11/10/14 indicates the patient showing improvements in terms of his range of motion to include 150 degrees of flexion and 150 degrees of abduction. The patient was continuing with postoperative therapy. The clinical note dated 11/24/14 indicates the

patient having returned to work with restrictions of no pushing or pulling. The patient was also instructed to avoid climbing stairs or ladders. The patient had continued to engage in strengthening exercises in the formal therapy setting. The patient was being recommended for a functional capacity evaluation at that time.

The Utilization Reviews dated 12/04/14 & 12/08/14 resulted in denials as insufficient information had been submitted confirming the patient's postoperative therapy having been completed and no evidence was submitted regarding an unsuccessful attempt at full duty.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient having undergone a left shoulder surgical intervention. There is an indication the patient has undergone postoperative physical therapy. However, it is unclear if the patient has completed a full course of treatment as the records are incomplete. Additionally, it appears the patient has returned to work with some duty restrictions to include a lifting restriction as well as to avoid climbing stairs. There is an indication the patient has essentially returned to full range of motion at the affected shoulder. No information was submitted regarding an unsuccessful attempt at full duty. Given these factors, a functional capacity evaluation is not appropriate for this patient at this time. As such it is the opinion of this reviewer that the requested functional capacity evaluation is not medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)